

Lifestyle Assessment Questionnaire

Please circle all that apply when there is a multiple choice question

CONFIDENTIAL – DONATIONS ACCEPTED

540-297-3593

I do not charge for this assessment, but donations are accepted as this takes time and work to do this for you. If you cannot afford to donate that is not a problem, but if you can please ask me how.

Please Note: Due to the laws of the land, we are required to tell you that the health information received during this consultation is for general education and is not intended to be specific medical advice. No medical care, diagnosis, or treatment is provided during this consultation. **It is advisable to consult with ones personal health care provider before implementing any lifestyle changes.**

I release all Lifestyle counselors or associated organizations from any and all liability. Participation in this consultation indicates acceptance of these terms.

Signature: _____ **Date:** _____

General Information:

Name: _____

Address: _____

Telephone: Home (____) _____ **Work:** (____) _____

Cell: (____) _____ **Email Address:** _____

Age: ____ yrs. **Sex:** Male Female

Marital Status: – (circle all that apply)

Single Married (1st / 2nd / 3rd or more) Divorced (1st / 2nd or more) Widowed

How long have you been married or divorced: _____

Weight: _____ lbs. **Height:** _____ **Sedimentation Rate:** _____

Blood Pressure: Left Side ____/____ Right Side ____/____ **Pulse** _____

Blood Glucose: _____ **Cholesterol:** _____ **HDL:** ____ **LDL:** _____ **Triglycerides** _____

Last BM you had? _____ **Color:** Orng Blk Brn Other **Size:** S M L **Hard or Soft**

On a Scale of 0-10, How serious are you about getting to the root of your problem/s? _____

On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition/s? _____ (within realistic limits)

Are you allergic to anything? YES or NO

***If yes, please list all that apply? _____

List any health concerns you have: (physical, mental, social or spiritual):

When did you last consult a physician? _____

Are you currently being treated for any ailments? YES or NO

***If yes, which ones?

Please list any surgery(ies) that you have had: (include the date)

What diseases/health condition(s) have you been diagnosed with? (Please list all)

Are you presently experiencing any of the following? (Please circle all that apply)

Anemia	Blurred vision	Constipation
Bad body odor	Chest Pain or Tightness	Cough
Bad Breath	Chills	Diarrhea
Bleeding	Clammy skin	Difficulty breathing
Bloated Stomach	Cold / Flu	Difficulty Hearing
Blood in stool	Cold hands or feet	Dizziness
Blood in Urine	Confusion	Earache
Excessive sweating	Insomnia	Parasites / Worms
Fainting	Itching in Rectal area	Rash
Fatigue	Joint Pain	Ringing in the Ears
Fever	Loss of Appetite	Seizures
Hair loss	Low Energy	Sensitivity to sunlight
Headaches	Memory loss	Sexual dysfunction
Heart palpitations	Nausea/Vomiting	Sores on Your body
Hemorrhoids	Neurosis	Stuffy Nose
Hives	Numbness/Tingling	Swelling anywhere
Increased Hunger	Pain	Taste Problems
Indigestion / Heartburn	Pain in the Eyes	Vision Problems
Infections	Painful Urination	Watery Eyes

Weight gain

Weight loss

Yellowing of Eyes

Do you suffer from any of the following emotional/mental disorders: (please circle all that apply)

Bipolar

Chronic anxiety

Co-dependency

Depression

Manias

Neurosis

Obsessive compulsive disorder (OCD)

Panic Attacks

Phobias

Schizophrenia

Worry

What specific condition(s) would you like this consultation to address?

Please list all medication (prescribed or OTC) you have taken in the last two months:

Please list all herbs or supplements (including vitamins) you have taken in the last two months:

On a Scale of 0-10, How serious are you about getting to the root of your problem/s? _____

On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition/s? _____

(Within realistic limits)

EXERCISE:

1. How many days a week do you exercise? 0 1 2 3 4 5 6 7

2. How many minutes do you exercise each day? _____minutes

3. What type of exercise/s do you do? (Please list all)

1. _____
2. _____
3. _____

4. Would you rate your exercise MILD MODERATE or VIGOROUS?

5. Do you exercise INDOORS, OUTDOORS, or BOTH?

***If indoors or both, DO YOU EXERCISE IN A GYM? YES or NO

6. Do you lift weights? YES or NO If yes, HOW MANY POUNDS? _____
7. Do you feel any pain when you exercise? YES or NO
***If yes, please rate on a scale from 1-10 (10 being the highest for pain) Pain Score: _____
8. Does your chest tighten when you exercise? YES or NO
9. What type of shoes do you wear while exercising? _____
10. Do you take any PROTEIN POWDER or SUPPLEMENTS to build strong muscles? YES or NO
***If yes, please list the brands/types: _____
11. Have you ever had a magnesium test done? YES NO NOT SURE
***If yes, what were your results? _____ Was this done by a blood test? YES NO

WATER:

1. How much do you weigh? _____ lbs.
2. How many cups (8 oz.) of water do you drink each day? _____ cups
How many cups have you drunk so far today? _____ cups
3. How much water do you drink upon arising in the morning? _____ (How many cups)
Is it SOFT or HARD water?
4. Do you SIP or GULP?
5. Do you drink with your meals? YES or NO
6. Do you drink cold water? YES or NO
7. Do you eat ice or put ice in your water/drinks? YES or NO
8. What type of water do you drink? TAP FILTERED SPRING DISTILLED BOTTLED
Which brand? _____
9. Do you have filtered water throughout your home (bathtub too)? YES or NO
10. Do your LIPS EVER FEEL DRY? YES or NO
11. Does your SKIN EVER FEEL DRY? YES or NO
12. Do you suffer from MIGRAINES or HEADACHES? YES or NO
13. What color is your URINE usually? CLEAR LIGHT YELLOW ORANGISH DARK YELLOW
TEA COLOR BROWN
14. Do you drink Vitamin Water? YES or NO
15. Do you drink Flavored Water? YES or NO

16. Do you drink KOOL-AID, PUNCH, or FRUIT JUICE? YES or NO

17. Do you drink fresh raw vegetable juice? YES NO SOMETIMES

***If yes, how often? _____

Which vegetables? Carrots, Broccoli, Beets, Cabbage, Potatoes, Greens, Etc.

18. Do you drink COFFEE? YES or NO

***If yes, how many cups a day? ____ cups

19. Do you drink TEA(Black, Lipton, Arizona, White, Chai, Green) YES or NO?

***If yes, how many cups per day? ____ cups

20. Do you drink SODA or DIET SODA? YES or NO

***If yes, how many cans per day? ____ cans

SUNSHINE:

1. How many days each week do you go out into the direct sunlight? ____ days

2. How many minutes do you get direct sunlight each day(list average amount)? ____ minutes
(sitting in front of a window does not count)

3. What time of the day do you mostly get your sunlight? 6:00 AM to 12:00 PM or 12:00 PM to 6:00 PM

4. Are you FAIR-SKINNED LIGHT SKINNED OLIVE COMPLEXION BROWN or DARK-SKINNED?

5. Do you wear sunglasses when out in the sun? YES or NO

6. Do you wear sunscreen? YES or NO

***If yes, which parts of your body? FACE ARMS LEGS CHEST BACK

7. Do you wear a hat when you go out into the sun? YES or NO

8. Do you feel faint when you are out in the sun? YES NO SOMETIMES

9. Have you ever had a Vitamin D (Hydroxy 25) test done? YES NO NOT SURE

***If yes, what was your results in number? ____ ng/ml

10. Do you take a Vitamin D supplement? YES or NO

***If yes, how many IU's each day? ____ IU's per day What Brand? _____

11. Are you ALLERGIC TO or BREAK OUT from the sun? YES or NO

TEMPERANCE:

1. Do you SMOKE, CHEW TOBACCO, DRINK ALCOHOL, or use ANY TYPE OF RECREATIONAL DRUGS?
YES or NO ***If yes to drugs, which ones?

2. Do you watch COMPETITIVE SPORTS, MOVIES, T.V. SHOWS, or NEWS? YES or NO
***If yes to movies, what type? ACTION, DRAMA, SUSPENSE, COMEDY, LOVE STORIES

3. Do you listen to music? YES or NO
What types? ROCK N ROLL, COUNTRY, SOUL, HIP HOP, POP, R&B, LOVE SONGS, JAZZ, TECHNO, HYMNS, CHRISTIAN ROCK, CHRISTIAN CONTEMPORARY, or CLASSICAL
4. Do you GAMBLE? YES or NO
(this can include lotteries, bingo, slots, cards, horse races, sports bets, etc.)
5. Do you get quick to ANGER? YES or NO
6. Do you have VIOLENT OUTBURSTS? YES or NO
7. Do you OVEREAT? YES or NO
8. Do you have any addictions that are not listed? YES or NO
***Just answer yes or no...please don't list addiction

AIR:

1. Do you have a hard time breathing? YES or NO
2. Do you do deep breathing exercises outdoors upon arising in the morning? YES or NO
***If yes, how many sets? _____
3. Right now, put your hand on your stomach and inhale!!! Did your stomach go IN or OUT?
4. Do you inhale through your NOSE or MOUTH?
5. Do you use your THROAT or STOMACH MUSCLES when you sing?
6. Do you slouch over when you STAND or SIT? YES or NO
7. Do you get fresh air every day? YES or NO
***If yes, how many minutes each day? _____ minutes
8. Do you air out your home every day? YES or NO
9. Do you sleep with your windows in your room cracked? YES or NO
10. Approximately How many square feet is your home? _____ sq. ft.
11. Do you have any plants in your home? YES or NO
***If yes, how many? _____ Which Kinds? _____
12. Do you live IN or NEAR an environment where the air is polluted? YES or NO

REST:

1. Do you take a nap every day? YES NO
***If yes, how often a week? _____ days _____ minutes
2. What time do you go to bed on average? _____ p.m.

3. What time do you wake up in the morning? ____ a.m.
4. Do you have a hard time getting to sleep? YES or NO
5. Do you have a hard time staying asleep? YES or NO
6. Do you wake up in the middle of the night to use the restroom?
***If yes, how many times? ____
7. Do you sleep with the LIGHTS, TELEVISION, RADIO, or COMPUTER on? YES or NO
8. Do you watch TELEVISION, or USE THE COMPUTER right before bedtime? YES or NO
9. Do you have nightmares? YES or NO
10. What times to you eat Breakfast: ____ Lunch: ____ Dinner: ____
11. Do you snack between meals? YES or NO
12. Do you do late-night snacking? YES or NO
13. Do you work the SWING or GRAVEYARD SHIFT? YES or NO
14. Do you drink ENERGY DRINKS, COFFEE, or ANYTHING WITH CAFFEINE IN IT? YES or NO
15. Do you take anything to sleep? YES or NO
***If yes, what is it? _____
16. Do you take one 24 hour period off every week where you don't cook, clean, run errands, do business, pay bills, shop, do laundry, etc.? YES or NO

NUTRITION:

1. Are you on any special diet? YES NO
***If yes, what type? _____
2. Do you eat any RED MEAT, PORK, FISH, CHICKEN, TURKEY, SEAFOOD, or ANY OTHER MEAT NOT MENTIONED? YES or NO
***If yes, how many times a day? ____ How many times per week? ____
3. Do you eat EGGS, CHEESE, BUTTER, MARGARINE, or ANY DAIRY PRODUCTS? YES or NO
4. Do you drink MILK? YES or NO
5. Do you use any Condiments such as MUSTARD, KETCHUP, MAYONNAISE, VEGGIENAISE, WORCESTERSHIRE SAUCE SOY SAUCE, BRAGGS AMINOS, VINEGAR, BOTTLED SALAD DRESSINGS, A-1 STEAK SAUCE, BBQ SAUCE, OR ANY NOT MENTIONED? YES or NO
***Please list any condiment not mentioned that you use: _____

6. Do you eat CHOCOLATE? YES NO
7. Do you use SUGAR, AGAVE, HONEY, MAPLE SYRUP, MOLASSES, SWEET N LOW, ASPARTAME, SPLENDA, EQUAL, STEVIA, CORN SYRUP, or ANY OTHER SWEETENER? YES or NO
***If yes to sugar, what kind? WHITE BROWN RAW TURBINADO SUCINAT?
8. Do you eat or use WHITE FLOUR, WHITE BREAD, WHITE RICE, and WHITE PASTRIES? YES or NO
9. How many times a day do you eat BREAD____x a day or PASTA____x a day
10. Do you eat “store bought” COOKIES, CAKE, CUPCAKES, BROWNIES, FUDGE, MUFFINS, BAGELS, CANDIES? YES or NO
***If yes, how often?
11. How many COOKED GREEN VEGGIES do you eat each day (peas and green beans are not veggies)?
_____ per day
12. How many COOKED ORANGE VEGGIES do you eat each day? _____
13. How many RAW____ or DRIED FRUIT____ do you eat each day?
14. Do you eat RAW VEGETABLES? YES or NO
***If yes, which ones? SPINACH, KALE, GREENS, BROCCOLI, CAULIFLOWER, BEETS, CARROTS, CABBAGE, GREENS, POTATOES, TURNIPS, ETC.
15. Do you eat fruit and veggies at the same meal(including fruit based dressings)?
YES or NO
16. How many servings of GRAIN(rice, corn, millet, rye, wheat, barley, oats, quinoa, etc.)
do you eat each day? _____
17. How many servings of RAW NUTS do you eat each day?_____
18. How many servings of RAW SEEDS do you eat each day?_____
19. Do you use SALT? YES or NO
***If yes, what kind?_____
20. Do you cook with OIL? YES or NO
***If yes, which ones? VEGETABLE, OLIVE, PEANUT, SAFFLOWER, SUNFLOWER, CANOLA, COCONUT, SESAME, PALM, or ANY OTHER?
21. Do you eat fried food(this includes French fries, chips, Fritos etc.)? YES or NO
***If yes, how often? ONCE A DAY, ONCE A WEEK, COUPLE TIMES A WEEK, COUPLE TIMES A MONTH?
22. Do you cook with or eat anything with FOOD COLORING? YES or NO
23. Do you use or eat NUTMEG, CINNAMON, ALL SPICE, WHITE PEPPER, BLACK PEPPER, RED PEPPER, HOT CHILIS, HOT SAUCE? YES or NO

24. Do you eat between meals? YES or NO
25. Do you CHEW GUM or eat ANY TYPE OF BREATH MINT? YES or NO
26. Do you read labels? YES or NO
27. Do you know the 25 Hidden names for MSG? YES or NO
28. Do you know what Aspartame is? YES or NO
29. Which of the following cookware do you use?: ALUMINUM, GLASS, STAINLESS STEEL, CAST IRON, CERAMIC, TEFLON, PORCELAIN, NEW FLIMSY BAKEWARE

*****These next three portions are in no way designed to judge or condemn; just simply to get an idea about each person*****

SPIRITUAL COMPONENT:

1. Do you believe in God? YES or NO
2. Do you pray to God? YES or NO
***If yes, how often a day? ____ x day
3. Do you believe the Bible is true? YES NO SOME OF IT
4. Do you read the Bible? YES or NO
***If yes, Which Version? _____
How Many Times? EVERY DAY ONCE A WEEK ONCE A MONTH ONCE A YEAR NEVER
5. Do you feel like God has been GOOD, BAD, or OKAY to you?
6. Do you feel you have been GOOD or NOT GOOD to God?
7. Do you trust God 100% implicitly? YES or NO
8. Do you believe God loves you? YES or NO
9. Do you believe God is LOVING and CARING or a MERCILESS TYRANT?
10. Do you take EVERYTHING to God when you have a problem or want some type of direction? YES or NO

SOCIAL:

(Please answer as truthfully as possible)

1. Do you have a good family unit? YES or NO
2. Are you close to your parents? YES or NO

3. Are you close to your children? YES or NO
4. Were you raised by your Biological parents? MOTHER or FATHER or BOTH? YES or NO
5. Were you raised with SIBLINGS, COUSINS, AUNTS, UNCLES? YES or NO
6. Do you get along well with others? YES or NO
7. Do you feel you have been cheated in life? YES or NO
8. Do you feel people misunderstand you? YES or NO
***If yes...MOST OF THE TIME or SOME OF THE TIME?
9. Are you a SENSITIVE PERSON or THINGS DON'T BOTHER YOU EASILY?
10. Do you have a social circle that you are a member of? (Church, Senior Center, Club, etc.)
YES or NO
11. Do you feel that you make good choices in picking friends and partners? YES or NO
12. Is there any unfulfilled promise you made that you wish you could fix? YES or NO
13. Is it easy for you to forgive others when they have wronged you? YES or NO
14. Are you willing to admit when you are wrong? YES NO SOMETIMES
15. Are you more SHY and TO YOURSELF or OUTGOING?
16. Are you an EMOTIONAL or SENSITIVE person, BOTH or NEITHER?
17. Do you feel your personality is ABRASIVE and HARSH or GENTLE and KIND?
18. Do you feel you are more of a LISTENER or TALKER?
19. Are you an OUTSPOKEN person or QUIET?
20. Would you consider yourself to be one who EXPRESSES YOURSELF & COMPLAIN when things don't go your way, or one who KEEPS IT IN TO YOURSELF?
21. Are you the type to tell all your personal business? YES or NO
22. Do you talk about others'? YES NO SOMETIMES
23. Are you more OPTIMISTIC or PESSIMISTIC?
24. On a scale of 0-100, what do you believe you are worth? _____

HYGIENE/CLEANLINESS:

1. Do you take a shower or bath every day? YES or NO
If no, how often do you do so in a week? _____ x week
2. Do you brush your teeth every day? YES or NO
If no, how often do you do so in a week? _____ x week
3. Do you brush your teeth after every meal? YES or NO What brand toothpaste do you use? _____
4. Do you change your clothes every day? YES or NO
5. Do you use deodorant? YES or NO What is the brand? _____
6. Do you use lotion? YES or NO
If yes, what kind? What is the Brand? _____
7. What kind of soap do you use? What is the Brand name? _____
8. What Brand of Shampoo do you use? _____
9. What Brand of Conditioner do you use? _____
10. Do you use any perfume or body spray? _____
11. Do you have animals living inside your home? YES or NO
12. Do you have animal feces lying near your home? YES or NO
13. Do you have dead leaves lying near your home? YES or NO
14. Do you have a compost bin near your home? YES or NO
If yes, how many feet away from the house is it?
15. Do you have carpet in your home? YES or NO
16. Do you vacuum every day? YES or NO
If no, how often in a week do you vacuum? _____ x per week
17. Do you clean your kitchen every day? YES or NO
If no, how often in a week do you clean it? _____ x per week
18. Do you mop every day? YES or NO
If no, how often in a week do you mop? _____ x per week
19. Do you wash your dishes every day OR do you leave them in the sink some days?
(circle that which applies)
20. How often in a week do you wash your clothes? _____ x per week

NOTES:

